Medical Coverage

Enrollment and Change Form

2015 Enrollment

I am a:

- ☐ Board of Education Employee
- ☐ Williamson County Government Employee

Select Appropriate Option:

- ☐ New Hire Enrollment, Provide Hire Date _____
- ☐ Life Changing Event/Qualifying Event, Date_____

  Circle one: Birth, Adoption, Marriage, Loss of Coverage Gained Coverage, Death, Court Order, Divorce
- ☐ Add Dependent(s)
- ☐ Terminate Dependent(s)
- ☐ Change Coverage from Option_____ to Option_____

****Enrollment due to a qualifying event requires proof validating the event.****

- ☐ Open Enrollment

Employee Name _____ **SSN#**_____ **Employee date of Birth**_____ **M or F**

Address: _____ **City:**_____ **State:** ____ **Zip:** _____

Best contact number (____ **)**_____ **e-mail** _____

Is your spouse a Board of Education or County Government Employee? Yes___ **No** ___ **If so, name of your spouse**_____

Enrollment Election

***Option 1 Deductible Plan w/ Health Savings Account**

☐ Individual Enrollment ☐ Employee + 1 Enrollment ☐ Family Enrollment

If you are enrolling in Option 1 Deductible Plan with H.S.A., **you must** set up your bank account as part of the enrollment process. Please follow the below URL link and use the enrollment ID provided for the online Bank Account set up of your H.S.A. through JP Morgan & Chase. (The Benefits Department is not responsible to complete this step)

https://preenroll.healthcare.cigna.com/healthcare/preenroll/app/bank/welcome.do

Enrollment ID : **WilliamsonHSA**

Choose the annual amount you would like to have withheld from your salary & placed into your H.S.A. account for eligible health care expenses. Your 2015 election may be $0 to $2,850 for individual coverage or $0 to $5,650 for Employee + 1 or family coverage. Any contribution made from the county, including funds from the H.R.A./Screening, will need to be subtracted from your individual or family maximums.

Annual Amount Elected: $_____

(once chosen, cannot be changed until next enrollment period)

Annual amount elected will be divided by the number of pay periods remaining in the plan year by the Benefits Department

***Option 2 Deductible Plan**

☐ Individual Enrollment ☐ Employee + 1 Enrollment ☐ Family Enrollment

☐ ***I Decline Medical Coverage.**

List all family members to be enrolled or terminated

First, M.I., & Last Name	SEX	Enrollment Election	Social Security #	Birth Date
Spouse	F M	Add Term	- -	- -
Child	F M	Add Term	- -	- -
Child	F M	Add Term	- -	- -
Child	F M	Add Term	- -	- -
Child	F M	Add Term	- -	- -

***Enrollment of a spouse**: The spousal form must accompany this enrollment form.

****Enrollment of a child**: Copy of the child's birth certificate must accompany this enrollment form.

By signing below, I agree to all terms and conditions of enrolling in and continued enrollment in the Williamson County Medical program, as such exist on the date of my enrollment as reflected below, and as such may change from time to time, with or without notice to me. I further represent and warrant that all information given by me is accurate, current and complete to the best of my knowledge. I agree to allow the Williamson County Benefits Department to have the appropriate deductions taken from my paycheck according to my above enrollment options.

Employee's Signature: _____ Date: _____